

ACCESS

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Division of Public Health
for all rural health stakeholders
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Community paramedicine and rural health care

by David Howe

SORH Contracted Rural Writer

The Rural Nebraska Regional Ambulance Network (RNRAN) is collaborating with a variety of health care professionals and organizations across Nebraska in establishing community paramedic pilot projects in three Nebraska communities: Scottsbluff, Kearney, and Omaha. Project coordinators are exploring this concept's potential for addressing concerns like costly hospital readmissions, unneeded emergency medical services runs, shortages in primary care services, and the upward trend of age-related health care needs.

According to Julie Smith, RNRAN Director at Kearney, the idea is to see if it is feasible to have Emergency Medical Services (EMS) personnel in rural communities fill the gaps in—not replace—health care services, Smith emphasized. In other words, EMS personnel, along with their role in emergency services, would provide non-emergency care within their scope of practice only where non-emergency care is not otherwise available, she explained.

That could involve such duties as assisting patients in following hospital discharge instructions, taking vital signs, doing medication reconciliation, monitoring weight, and informing patients of health care services available to them, according to Smith.

"This (exploring the potential of community paramedicine) has been several years in development here in Nebraska and in several areas around the country," she said.

A lot of groundwork preceded RNRAN's assignment to coordinate the establishment of the pilot community paramedic projects, according to Dean Cole, EMS Administrative Director in the Nebraska Department of Health and Human Services, and Carrie Crawford, Northeast Regional EMS Specialist of the Nebraska EMS/Trauma Program. With a grant from HRSA (Health Resources and Services Administration) about five years ago, a wide net was cast to "bring people together to share different ideas," said Cole. They were "people whom we thought would be touched by this sort of thing," he added.

Those stakeholders included such organizations as the Nebraska Nurses Association, the Nebraska Hospital Association, Creighton University School of Medicine, the University

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of Nebraska Medical Center, community action organizations, and home health care organizations, according to Cole and Crawford.

That collection of ideas then became the starting point for RNRAN's role in coordinating the establishment of pilot projects in Scottsbluff, Kearney and Omaha, Cole and Crawford said. Various health care entities working under the umbrella of RNRAN—not just EMS providers—are coordinating the pilot projects in the three Nebraska communities.

The intent is to avoid duplicating or displacing existing sources of care in any community. "We don't want it (community paramedicine) to be a competition, but rather a collaboration of available and appropriate resources" said Crawford. The community paramedic will work to connect the patient with available services in a community, assisting in referrals to home health, social services and other appropriate programs, she added.

Planners involved in RNRAN's coordination of paramedicine pilot projects include the Association of Home and Community Health Agencies, Cole and Crawford in the Nebraska DHHS EMS Department, and various other health care organizations and individuals in the communities where the pilot projects are, according to Smith.

"The key thing is that this is just exploratory right now," Cole said. "There are fewer and fewer caregivers in these small towns. We don't want to get into the home health thing." But where it's not available, he continued, EMS personnel could be available on a non-emergency basis. The goal is to see if paramedics are a feasible way to fill these care gaps.

RNRAN Network Director Smith said that although grant applications for funding pilot paramedicine projects in Nebraska have not been funded, there are three communities where the pilot projects are being implemented. She said that these are operating on a self-supporting basis by the pilot project collaborators.

Patients are not billed for services under the pilot program, and there is no provision for Medicaid/Medicare payer reimbursement for non-emergency care from EMS personnel in the pilot projects, according to Smith. Collaborators in the pilot projects hope to see if costs of providing non-emergency paramedicine are offset by reductions in hospital readmissions and unnecessary 911 calls, she explained.

Scottsbluff's project, which hopes to begin this month, is the farthest along of the three projects, she said. "Valley Ambulance partnered with Regional West Medical Center.

Together, they have asked for input from the Community Action Agency of Western Nebraska, Scotts Bluff County Health, and other agencies to understand programs that may be available but are underused by qualifying patients."

This pilot project is focusing on hospital discharge of patients with congestive heart failure and pneumonia, according to Smith. These are patients who don't qualify for home health care. Congestive heart failure and pneumonia were chosen because they are two of the common diagnoses for hospital readmissions and use of 911 calls for treatment in emergency rooms, according to Smith.

Paramedics go to the patients' homes on a non-emergency basis to provide services.

In the Scottsbluff pilot project, patients being discharged from the hospital who do not meet the criteria for home health will be assigned, on an alternating basis, either an RN or a paramedic for follow-up care. One patient, gets an RN, the next patient a paramedic, and so on. After six months, outcomes will be compared between patients receiving follow-up care from RNs and those receiving follow-up care from paramedics, Smith explained, "to see if there are any differences in outcomes."

The electronic record system that paramedics complete for patients on 911 calls

(electronic Nebraska Ambulance and Rescue Service Information System or e-NARSIS) will be utilized for the documentation and data collection for the Scottsbluff pilot. This is being developed to see how it can be made to accommodate a non-emergency patient care record, and to evaluate its capability of being integrated with the patient's primary care provider's electronic medical record in the future, Smith said.

In Kearney, the pilot project is being implemented through Buffalo County Community Partners, with a "patient navigator" approach, according to Smith. Patient navigators, which could be EMS personnel, may be utilized in the care of congestive heart failure patients and pneumonia patients upon discharge from the hospital. Navigators will be advocates for those patients, helping them with follow-up physician visits and identifying necessary care services that could help them avoid the need for emergency medical transport and hospital readmission, Smith said.

Care includes services such as those previously outlined: Assisting patients with following hospital discharge instructions, weight monitoring, medication reconciliation, taking vital signs, etc. "That's one focus of these projects: reducing 30-day readmissions to the hospital," Smith said.

The pilot paramedic project in Omaha is "in its infancy," Smith said, with much of the planning just getting underway. One of the collaborators there is Medics at Home, which also has rural ambulance services. Paramedicine isn't necessarily limited to rural areas, according to Smith. It might be appropriate in some underserved urban locations, she said.

Smith emphasized that paramedicine programs can be highly individualized, tailored to the specific needs of a community. And needs can vary widely among communities, they added. "That's why it's kind of nice to have several communities (in Nebraska) that we can compare data with," Smith said.

There are other paramedicine programs in the U.S., including Colorado, Alaska, and Minnesota, and in other countries, including Canada, Scotland, and Australia.

A curriculum for community paramedics has been developed by the North Central EMS Institute (NCEMSI) and is free to community colleges, who want to utilize it. "It's a national curriculum," Crawford said. "To my knowledge," said RNRAN's Smith, "no community colleges (in Nebraska) have adopted it at this time." The program is available online and has been coordinated through the NCEMSI.

Smith, Cole, and Crawford emphasize that Nebraska is just in the exploratory stages of community paramedicine. Collection and analysis of results from the three Nebraska pilot projects will help serve as guidelines on what the next steps should be, they noted. □

**For Shortage Area designations and more
information on the Incentive Programs,
go to our website:**

http://dhhs.ne.gov/publichealth/Pages/hew_orh.aspx

A 2012 national retention study of federal program health care clinicians

The National Health Service Corps conducted a national stratified sample of health care clinicians who have received scholarships and loan repayment for serving in a federal health professional shortage area. The study findings show that short-term retention was 82 percent (defined as staying up to one-year after service completion) and long-term retention was 55 percent (defined as staying in a shortage area 10 years after service completion) for those practicing in an underserved area. The policy brief for this study may be found at: <http://nhsc.hrsa.gov/currentmembers/membersites/retainprovider/retentionbrief.pdf>

The National Health Service Corps study involved 11 states that were interested in exploring the factors associated with the retention of health care clinicians serving in underserved areas. This state retention collaborative study was led by Thomas Rauner, Nebraska Primary Care Office Director and conducted by Dr. Don Pathman, who is with the Sheps Center at the University of North Carolina. In this study of the retention rates of physicians and other eligible health care professionals who served in the National Health Service Corps, or received funding from a state incentive program are compared.

In the next issue of the Access newsletter we will share some of the findings of the Multi-state/NHSC Retention Collaborative. This 71-page report is available at the following web site: http://dhhs.ne.gov/publichealth/Documents/Multi-State%20NHSC%20Retention%20Collaborative%20Final%20Report_Nov%205%202012.pdf

For more information, contact Thomas Rauner at thomas.rauner@nebraska.gov, (402) 471-2337 □

MARK YOUR CALENDARS

Nebraska Rural Health Advisory Commission Meeting

Friday, March 15, 2013, 1:30 p.m., Lincoln, NE

NRHA Annual Conference

May 8-10, 2013 - Louisville, KY

Nebraska Rural Health Advisory Commission Meeting

Friday, June 21, 2013, 1:30 p.m., Lincoln, NE

Nebraska Rural Health Advisory Commission Meeting

Thursday, September 19, 2013, 6:00 p.m., Kearney, NE

2013 Nebraska Rural Health Conference

September 18 and 19, 2013

Younes Conference Center - Kearney, NE

CRHC Billing & Coding Workshop

September 18, 2013

Younes Conference Center, Kearney, NE

Nebraska Rural Health Advisory Commission Meeting

Friday, November 22, 2013, 1:30 p.m., Lincoln, NE

The “stress” in rural health care

By John L. Roberts, MA
Executive Director, NeRHA

The rural health care system has changed dramatically over the past decade because of a general transformation of health care financing, the introduction of new technologies, and the clustering of health services into systems and networks. Despite these changes, resources for rural health systems remain relatively insufficient.

Many rural communities continue to experience shortages of physicians, and the proportion of rural hospitals under financial stress is much greater than that of urban hospitals. The health care conditions of selected rural areas compare unfavorably with the rest of the nation. The market and governmental policies have attempted to address some of these disparities by encouraging network development and telemedicine and by changing the rules for Medicare payments to providers. The public health infrastructure in rural America is not well understood in terms of its role in the rural health care continuum.

Change is not likely to slow down anytime soon in rural health and in fact will most likely increase as we implement many aspects of the Affordable Care Act. So all this change leaves me with a burning question, how we manage the epidemic of “stress” in healthcare. “Stress” means two different things that are often mixed up. It is the pressure we face to change, the “stress” we are under. But it is also how we respond to that pressure, how “stressed out” we become.

We need some stress. It leads to creativity. It leads to the risk taking necessary for individual and corporate growth. It helps us to avoid boredom. If you aren’t feeling any stress, you may want to check to see if you have a pulse. But we also know, too much stress is bad for your health.

The Mayo Clinic reminds us “stress symptoms may be affecting our health—like a nagging headache, frequent insomnia or decreased productivity at work.” When you feel under stress, your body releases a burst of hormones to fuel your capacity for a response. Unfortunately, under nonstop stress that alarm system rarely shuts off and the negative effects add up.

A recent much publicized study from Harvard University found that leaders feel less stress than others. The researchers didn’t know if the leaders felt less stressed because of their role at work. Or are those who handle stress well more likely to become part of leadership?

For the sake of my colleagues in rural health, I hope this research has it right. But I’m not convinced. I look at what is being thrown at everyone in health care today and shake my head. I have worked in health care in Nebraska for three decades and have never seen these levels of overall stress.

I am not arguing for the “good old days.” Today’s stress on the health care system is in good measure because of key issues too long ignored. Issues such as improving the quality and cost of health care have appropriately become a top national priority. Health care’s success in attracting a large share of our country’s resources is causing a push back from both public and private sector payers. Health care is facing a critical mass of people saying, “Enough already.”

Health care, for the foreseeable future, will be under substantial stress. Each of us alone can’t control all of what is happening to us, but we can choose how we respond to it.

John Ryan is president of the Center for Creative Leadership, a global provider of executive education and a former Navy pilot and retired Vice Admiral. He believes that managing individual stress comes down to these critical elements: “maintaining perspective, exercising, opening up, welcoming feedback, streamlining, and recharging.”

But those in leadership positions can go a step further. In rural health care, we need to be in the business of creating health, not adding to illness. We need to work within our organizations and help develop public policies that will reduce the high levels of stress being experienced by those working in the health care sector.

We need to start asking how providers, payers, and regulators can work together in a healthier way. There are no easy answers on a host of differences around the future of health care, but saying “yes if, rather than no, because” is a good place to start. □

Making it about more than dollars in and dollars out

by David Howe

SORH Contracted Rural Writer

You may recall a TV ad in which the advertiser says that it doesn't make the product, it makes the product better.

Maybe the same could be said of a model that two rural Nebraska hospital foundations are following to enhance charitable giving. Fillmore County Hospital Foundation in Geneva and Box Butte General Hospital Foundation in Alliance are adopting practices to make charitable giving better--better for the donors and better for their communities.

The models' focus is broader than hospital projects based on whatever donations they happen to receive. It's more of a "proactive" approach than a "reactive" one, said Jim Gustafson, Gift Planning Director of the Nebraska Community Foundation (NCF), which works with a variety of local charitable organizations in various ways across the state.

NCF is helping the hospital foundations in Alliance and Geneva set up long-range planning for giving, coupled with long-range, comprehensive, community-wide goals for the physical and economic health of the community. That stands in contrast to short-term fundraising that a local foundation might typically follow for a specific project or purchase, according to Gustafson.

He uses hunting versus farming as an analogy to illustrate NCF's role in the model adopted by the foundations in Alliance and Geneva: In hunting, "It's shoot, and it's over," he said. In farming, it's a sequence of coordinated steps over an extended time that leads to fruition of carefully planned goals. "This is a long-term relationship," he said.

NCF's role with the two hospital foundations is to provide them with expertise in setting up this approach and implementing it. Gustafson likens NCF's assistance to a rocket launch, where it takes a lot of preparation and energy to get off the launch pad. But once on the way, the local foundations can continue their course with less counterforce to overcome.

Seed money for development of the model comes from the Denny Berens Rural Health Fund. Former Nebraska Office of Rural Health Director Denny Berens (now retired) donated to NCF a professional recognition cash award he received. He donated the money for the purpose of using it in conjunction with matching funds from two participating rural Nebraska hospital foundations interested in implementing the approach described in this article.

Asked about his intent in conjunction with his donation, Berens responded: "The purpose of this new foundation model is to help rural communities, with hospitals, understand that health and health care are an important role and need for all of the area's citizens. This is an investment model, rather than a pure donation model that has been often used in the past."

The goal is to help the whole community focus on creating a sustainable health and health care foundation model "that goes beyond the traditional hospital-only focus," he said. "The Nebraska Community Foundation has the vision, the model, and the people to help hospital foundations explore this new role—a model that is truly rural and focused on sustainability and caring," Berens added.

Through a screening process, two hospital foundations at opposite ends of the state were to be chosen for NCF's services in this endeavor. The hospital foundations in Alliance and Geneva were selected through that screening process.

Box Butte General Hospital Foundation Director Brooke Shelmadine in Alliance describes what NCF offers as a "methodical approach." Before the 16-year-old Box Butte Health Foundation adopted the model about 18 months ago, it had no formal endowment-building process or long-range planning, she said. One of the biggest benefits so far, Shelmadine added, is NCF's educational services on giving. "That information has turned on a light bulb for our community."

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"We are a very charitable community," she continued. But there is a need for education on the best ways to plan charitable giving, she said. "Sometimes their (donors') charitable interest is not the Box Butte General Hospital Foundation." It might be to another local cause such as their church, she added, but "we are happy to see the funds stay in our community."

And in Geneva, Fillmore County Hospital Foundation Liaison Kim Gewecke commented, "What the Nebraska Community Foundation has brought to us is understanding what it takes to accomplish goals in providing health care in a rural community."

Some of that understanding comes from success stories that Gustafson shares with the directors of the hospital foundation from other foundations with whom NCF has collaborated, said Gewecke. "The teaching we've received from the Nebraska Community Foundation is invaluable."

Like Shelmadine in Alliance, she describes the Fillmore County community as giving-minded. The hospital foundation there had already stepped up its effort in fundraising before its affiliation with NCF a little over a year ago. It had formed a "Builders Club," she said. Representatives from eight towns in the county were tapped as foundation directors to help with fundraising. "You need to hear the voice of everybody," she added. A gala for fundraising, organized by the Builders Club, attracted 400 people which was surprisingly successful, she said. So, the foundation already had some momentum before joining forces with NCF a little over a year ago.

Now the foundation is being pushed "to another level" through its collaboration with NCF, she said. "We are still in the beginning process of setting goals."

Rural communities have potential donors who wish to be a part of their communities' future physical and economic well-being, Gustafson noted. But it's not always easy for a rural hospital foundation to come up with the resources and expertise to help donors maximize benefits to themselves and to the recipient organizations, he said.

Unlike hospital foundations in large cities or those affiliated with nationally recognized institutions like the Mayo Clinic, Gustafson said, a rural foundation is less likely to have staff resources and expertise to:

- Identify and attract donors.
- Work with donors and their financial planners on how to structure their giving for the fullest benefit to the donors, taking into account such factors as tax impact.
- Fulfill the donors' wishes to the fullest extent possible for what they want their donations to accomplish in their community.

That's what the model developed between NCF and the hospital foundations in Alliance and Geneva is designed to do.

"We don't do the work for them (local foundations). We train them on how to do the work," Gustafson said. "We didn't set this up to measure how many gifts we receive."

Donors might be someone who "has a passion for the hospital" stemming from, for example, care received at the hospital or experience there as a volunteer. The next step is not necessarily having donors make a gift, but thinking about what's possible—to help people think about what they can contribute to their community and the life there for their family, according to Gustafson. The possibilities might not even be for the hospital directly but for the community as a whole. "We truly believe at the Nebraska Community Foundation that a rising tide raises all ships," Gustafson said.

A 2011 Transfer of Wealth Study commissioned by NCF indicates that \$600 billion of wealth is likely to transfer between generations over the next 50 years in Nebraska, according to Gustafson. That's up 84 percent from what was shown in a 2002 study by the Center for Rural Entrepreneurship. "The peak years for wealth transfer are on the near horizon in 51 of Nebraska's 93 counties," he said.

That transfer of wealth for the benefit of the local community, rather than out of the community, is an important consideration, Gustafson said. □

State and federal mental health shortage areas

By Thomas Rauner, Federal Incentive Programs

Marlene Janssen, Nebraska Rural Incentive Programs

Marlene Deras, Health Professional Tracking Service

This is the last in a series of articles that have focused on how state and federal shortage areas are designated for purposes of different government programs and the collaboration between different state and federal agencies to identify these shortage areas. Previous articles have discussed primary care, dental, and allied health shortage areas. This article looks at mental health shortage areas.

Mental Health shortage area designations are a collaborative process between the Office of Rural Health (ORH) and the University of Nebraska Medical Center, Health Professions Tracking Service. The Health Professions Tracking Service (HPTS) began documenting the location and retention of Nebraska's mental health professionals in 2007. Since that time, HPTS has surveyed Nebraska mental health professionals annually. The professionals included in the HPTS survey process are; psychiatrists, nurse practitioners and physician assistants specializing in psychiatry, psychologists, licensed mental health practitioners, master social workers, and licensed alcohol and drug counselors.

Survey responses enable HPTS to link professionals and practice location data together in a relational database. Since the accuracy of HPTS data is directly linked to the survey responses, confirmation or updating the information on the survey is essential. The comprehensive approach identifies practicing professionals, practice specialties and practice locations (primary and satellite) throughout the state of Nebraska. HPTS data are used for federal and state shortage area designations. Even if the data on the survey have not changed, it is important to confirm that the information is correct.

State-Designated Psychiatrist/Mental Health Shortage Areas

In this section of the article, the focus is on the specific criteria used to identify state-designated psychiatry and mental health shortage areas. Approved mental health specialties include psychiatrists, physician assistants specializing in psychiatry, psychiatric nurse practitioners, psychologists, and licensed mental health practitioners. The Rural Health Advisory Commission is responsible for establishing the shortage area guidelines and approving the state-designated shortage areas.

The Rural Health Advisory Commission, with assistance from the ORH, has developed the methodology for defining state-designated, health professional shortage areas through working with professional associations, local communities, state lawmakers, government agencies (federal, state, and local), and interested parties. According to the Rural Health Systems and Professional Incentive Act, *"...in making such designations the commission shall consider, after consultation with other appropriate agencies concerned with health services and with appropriate professional organizations, among other factors: (1) the latest reliable statistical data available regarding the number of health professionals practicing in an area and the population to be served by such practitioners; (2) inaccessibility of health care services to residents of an area; (3) particular local health problems; (4) age or incapacity of local practitioners rendering services; and (5) demographic trends in an area both past and future."* (Nebraska Revised Statutes, §71-5665.)

Active psychiatrist records supplied by the HPTS are used to determine shortage areas. After these records are sorted and truncated so only rural psychiatrist records are left, the ORH normalizes practice hours per week to a 40-hour work week. The objective is to have one record for each psychiatrist practicing in a particular county. Next, a full-time equivalency (FTE) report is generated by county.

Determining psychiatrist/mental health shortage areas also requires the latest county Census data. The Office of Rural Health then calculates the population to psychiatrist FTE ratio for each

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county. As per the commission's guidelines for psychiatrist/mental health shortage areas, counties or parts of counties within a 25-mile radius of Lincoln or Omaha will not be designated. Counties with a population to psychiatrist FTE ratio greater than or equal to 10,000/1 are considered state-designated psychiatrist/mental health shortage areas. Currently areas outside a 25-mile radius of Lincoln and Omaha are designated as state-designated psychiatrist/mental health shortage areas.

While the Rural Health Advisory Commission's shortage area guidelines for mental health only consider psychiatrist FTE, this could change as HPTS develops reliable psychologist and licensed mental health practitioner FTE data. If the commission recommends such a change there would be a 30-day public comment period before any change to the guidelines would occur.

While the Nebraska Office of Rural Health is not the only user of HPTS data, this information is critical in the designation process for health professional shortage areas both at the state and federal level. So when a health professional receives a survey from HPTS in the mail or a telephone call from the HPTS staff, it is important to respond with accurate information.

Federal Mental Health Professional Shortage Area (HPSA) Designations

One of the primary functions of a health professional shortage area designation is to aid in determining loan repayment awards and The National Health Service Corps (NHSC) uses the HPSA score to prioritize them. The number of mental practitioners receiving federal loan repayment is significantly higher in Nebraska compared to primary care and dental providers because mental health HPSA scores are higher. NHSC program requirements may be found on its website at: <http://nhsc.hrsa.gov/sites/becomenhscapprovedsite/index.html>.

The Primary Care Office uploads the HPTS data into the federal Office of Policy and Shortage Designation geographic information software program (ASAPS) in order to define federal shortage area designations. In Nebraska, we primarily use facility and regional geographic designations to define federal mental health professional shortage areas. Each of these designation types incorporate slightly differing designation criteria which is cumbersome to explain but is available at: <http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/mentalhealthhpsacriteria.html>.

The most common types of facilities in Nebraska, which receive an "automatic" federal mental health professional shortage area designation, are Community Health Centers, Indian Health Services and Medicare Certified Rural Health Clinics. In order for a facility to have a federal "automatic" designation it must meet the guidelines of the National Health Service Corps program by complying with their program requirements. The major requirements of a NHSC site is to see everyone regardless of their ability to pay by using a sliding fee schedule, being culturally competent, being part of an integrated health care delivery system and accepting all forms of public and private insurance.

Geographic designations are the most frequently used in Nebraska to denote areas with a shortage of psychiatrists and other mental health professionals. The major factors used in mental health designations are: a population to psychiatrist ratio of 30,000 to 1, psychiatrists in a 40 mile contiguous area who are over utilized, excessively distant, or inaccessible to the population. In Nebraska we have not needed to utilize a more in-depth analysis of other non-psychiatric mental health providers in order to demonstrate a shortage of mental health access. Currently five of the six regional mental health areas qualify as federal shortage areas leaving only the 5 counties in Region VI near Omaha which do not qualify. We continue to use the HPTS to assist in federal shortage area designations and provide guidance on mental health workforce needs in Nebraska. A map of Nebraska federal mental shortage area designations is available on our website at: <http://dhhs.ne.gov/publichealth/Documents/HPSA%20Mental%20Health%202012.pdf>

For more information contact: Marlene Deras, HPTS, (402) 559-2972; Marlene Janssen, Nebraska Rural Incentive Programs, (402) 471-2337; or Tom Rauner, Federal Incentive Programs, (402) 471-2337. □

MUVers are 'moving' health care forward

By Jennifer Rathman, Wide River TEC

"Although the transition to electronic health records can be challenging, I don't know how I could practice without it at this point," said Dr. Mark W. Woodruff of Omaha. Dr. Woodruff's insight regarding electronic health records (EHRs) is proven to be invaluable to other practitioners who are considering making the switch from paper records to EHRs. Because of this, Dr. Woodruff and thousands of other providers across the country are joining the Meaningful Use Vanguard (MUV). The MUV program was created by the U.S. Department of Health and Human Services Office of the National Coordinator for Health Information Technology (ONC) to encourage providers to share their health information technology (HIT) stories and highlight their experiences. Wide River Technology Extension Center (TEC), Nebraska's Regional Extension Center, adopted the MUV program for Nebraska providers to highlight the excellent work they see in the state's clinics and facilities. In August, Wide River TEC added seven new individual MUVers and one critical access hospital to the MUVer list.

The definition of vanguard is the foremost position in an army or fleet advancing into battle. This is a great depiction of these providers who are leading the way in adopting new and challenging technologies. The goal of the MUV program is to establish a cohort of regional and local champions of EHR adoption and meaningful use who will serve as local advisors. The ONC provides the framework and guidance for the program; the local Regional Extension Centers (RECs), such as Wide River TEC, are responsible for recruiting and maintaining those relationships. Many RECs across the country are leveraging these early adopters to advance their outreach and education efforts, and research has indicated that peer-to-peer learning results in higher achievement and greater productivity. Wide River TEC, Nebraska's REC, utilizes MUVers in speaking engagements, educational events and to help other clinicians overcome the seemingly insurmountable challenges of implementing and optimizing their EHRs.

Emily Krohn, from Boone County Health Center in Albion, shared her experience when she was a panelist at the Advancing HIT in Nebraska conference in Kearney in October, an event hosted by Wide River TEC. Krohn stated, "It puts the information wherever the patient presents and where the clinician needs it. Not in a nurse's pocket or a room full of charts, but where they need it, when they need it."

"These MUVers are the local champions in their community who each have a unique story to tell and lessons to share on what made them successful. It is incredibly important to connect providers and office staff with their peers in their endeavors to achieve meaningful use and beyond," said MUVer Lead at the ONC, Lisa-Nicole Danehy.

Nebraska MUVers and thousands of other MUVers from across the country are at the forefront of EHR implementation and meaningful use. To learn more about Nebraska's MUVer program and to read their stories, visit www.widerivertec.org/home/muv.aspx. For more information, contact Jennifer Rathman at jrathman@widerivertec.org □

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Our library of back issues is available on the Web at www.dhhs.ne.gov/orh.

Questions? Need help? Contact Ann.Larimer@Nebraska.gov, (402) 471-2337.

Medicare EHR incentive program: learn about payment adjustments and hardship exceptions

By Jennifer Rathman, Wide River TEC

Most Medicare eligible professionals (EP), eligible hospitals, or a Critical Access Hospitals (CAH) are in the process of implementing or upgrading their electronic health records (EHRs) and demonstrating the federal meaningful use requirements. Implementing EHRs early in the process will allow eligible physician clinics and hospitals to qualify for monetary incentives. However, payment adjustments in the form of monetary penalties will be applied if you do not demonstrate meaningful use of certified electronic health record (EHR) technology. Information about the meaningful use requirements and the incentives can be found at <http://www.cms.gov/regulationsandguidance>.

An Overview of Payment Adjustments

Payment adjustments for providers eligible for the Medicare EHR Incentive Program are based on an EP's prior reporting periods. The length of the reporting period depends upon the first year of participation.

For Medicare EPs: Payment adjustments begin on January 1, 2015. The payment adjustment is one percent per year, cumulative for every year that an EP is not a meaningful user. The maximum cumulative payment adjustment is five percent.

For Medicare Subsection (d) Eligible Hospitals: Payment adjustments begin on October 1, 2014. The payment adjustment is applicable to the percentage increase to the Inpatient Prospective Payment System (IPPS) rate. Hospitals that do not demonstrate meaningful use will receive a lower payment than the IPPS standard amount. The payment adjustment is cumulative for each year that a Medicare Subsection (d) eligible hospital does not demonstrate meaningful use.

For CAHs: Payment adjustments will begin with the fiscal year 2015 cost reporting period. The payment adjustment for CAHs applies to their Medicare reimbursement for inpatient services during the cost reporting period in which they did not demonstrate meaningful use. If a CAH has not demonstrated meaningful use, its reimbursement would be reduced from 101 percent of its reasonable costs to 100.66 percent.

All Medicare EPs, eligible hospitals, and CAHs *must* continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

Categories for Hardship Exceptions

Under certain circumstances, hardship exceptions will be granted to EPs, eligible hospitals and CAHs. Through an application process, providers must demonstrate to CMS that those circumstances pose a significant barrier to achieving meaningful use.

The categories for EPs to use to apply for hardship exemptions include infrastructure, newly practicing EPs, and unforeseen circumstances. EPs can also apply for exceptions based on their specialty or if they practice in multiple locations.

The categories for eligible hospitals and CAHs to use to apply for hardship exemptions include infrastructure, new CAHs, and unforeseen circumstances. View the CMS tip sheet on payment adjustments to read about the circumstances on the Stage 2 website: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Stage_2.html.

Information on how to apply for a hardship exception will be posted on the CMS EHR Incentive Programs website www.cms.gov/EHRIncentivePrograms.

If you need additional assistance, please contact Wide River TEC, Nebraska's Regional Extension Center, at 402-476-1700 or via email at info@widerivertec.org. □